TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH OF PLANO

Respondent Name
AMGUARD INSURANCE COMPANY

MFDR Tracking Number
M4-17-1934-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 23, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "They processed the OR line as ER line & did not pay for the ER at all!"

Amount in Dispute: $1,392.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the documentation received, Coventry is standing on it's review of the fee schedule review and pricing. . . Bill was denied correct. . . . Bill is priced correct."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2016 to February 28, 2016	Outpatient Hospital Services	$1,392.14	$1,392.14

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING
   - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL, ALLOWANCE AMOUNTS DO NOTO REFLECT PREVIOUS PAYMENTS.
   - BL – ADDITIONAL ALLOWANCE IS NOT RECOMMENDED AS THIS BILL WAS REVIEWED IN ACCORDANCE WITH STATE GUIDELINES, USUAL AND CUSTOMARY POLICIES, OR THE PROVIDER'S PPO CONTRACT.
   - Z652 – [No description of this explanation code was found with the submitted materials.]
   - 94 – PROCESSED IN EXCESS OF CHARGES.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - P12 – [No description of this explanation code was found with the submitted materials.]
   - P300 – [No description of this explanation code was found with the submitted materials.]
   - MOPS – [No description of this explanation code was found with the submitted materials.]
   - ZOBC – [No description of this explanation code was found with the submitted materials.]
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds no information presented to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. The insurance carrier denied disputed services with claim adjustment reason code 4 – "THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING."

   28 Texas Administrative Code §134.203(b) requires that,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;

   The applicable Medicare payment policy is found in *Medicare Claims Processing Manual*, Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services, §10.6 - Functional Reporting (available from CMS at this link:www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf)

   Per §10.6, G. *Required Reporting of Functional G-codes and Severity Modifiers*:

   > Functional reporting using the G-codes and corresponding severity modifiers is required reporting on specified therapy claims. Specifically, they are required on claims:
   >
   > - At the outset of a therapy episode of care (i.e., on the claim for the date of service (DOS) of the initial therapy service) . . . and
   > - When an evaluative procedure, including a re-evaluative one, (HCPCS/CPT codes 92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004) is furnished and billed

The disputed therapy services meet both of the above conditions, therefore the provider was required to bill up to three functional G-codes indicating current status, goal status and discharge status. While the provider did actually bill three required functional G-codes (G8978, G8979, and G8980), the policy also requires use of specific modifiers:

- a severity modifier in the range CH–CN, used to report the severity/complexity of the functional limitation.
- The related discipline modifier: GP, GO or GN indicating PT, OT, and SLP services, respectively

While the provider did bill the required discipline modifier (GP), the required severity modifiers (range CH to CN) were not appended to the G-codes and are missing from the bill. The insurance carrier's denial reason is thus supported with respect to physical therapy procedure codes 97001 and 97116 and additional reimbursement cannot be recommended for these services.

Per Medicare payment policy, the functional G-code reporting requirement applies only to the reimbursement of therapy services (disputed procedure codes 97001 and 97116) and does not apply to any other codes billed on the claim. For this reason, the insurance carrier's use of claim adjustment reason code 4 with respect to non-therapy services is not supported. Reimbursement for those codes will be reviewed per applicable division rules.

3. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

4. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and services without procedure codes is packaged into the payment for the APC. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 99285, February 27, 2016, has status indicator J2, denoting hospital, clinic or emergency room visits (including observation/critical care services) subject to composite payment if certain other services are billed in combination. This is classified under APC 5025, which, per OPPS Addendum A, has a payment rate of $486.04, multiplied by 60% for an unadjusted labor-related amount of $291.62, which is multiplied by the facility's annual wage index of 0.9731 for an adjusted labor amount of $283.78. The non-labor related portion is 40% of the APC rate, or $194.42. The sum of the labor and non-labor portions is $478.20. The cost of these services does not exceed the annual fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific reimbursement for this line of $478.20 is multiplied by 200% for a MAR of $956.40.
   - Procedure code 96376 and G0378, February 27, 2016, have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
   - Procedure code 73562 and 93005, February 27, 2016, have status indicator Q1, denoting STVX-packaged codes — reimbursement is included in the package for any service with status indicator S, T, V or X; this code is not separately payable unless no other status S, T, V or X code is billed on the same claim. Reimbursement for this service is included in the payment for procedure code 96374 and 96375 billed on the same claim. The use of a modifier is not appropriate. Separate payment is not recommended.

- Procedure code 85025, 85610 and 85730, February 27, 2016, have status indicator Q4, denoting packaged laboratory services. Reimbursement for this service is included in the payment for procedure code 99285, 96374 and 96375 billed on the same claim. The use of a modifier is not appropriate. Payment for the packaged services is included in the reimbursement for the primary service(s). Separate payment is not recommended.
- Procedure code 96374, February 27, 2016, has status indicator S, denoting significant OPPS procedures paid separately by APC, not subject to reduction. This is classified under APC 5693, which, per OPPS Addendum A, has a payment rate of $92.40, multiplied by 60% for an unadjusted labor-related amount of $55.44, which is multiplied by the facility's annual wage index of 0.9731 for an adjusted labor amount of $53.95. The non-labor related portion is 40% of the APC rate, or $36.96. The sum of the labor and non-labor portions is $90.91. The cost of these services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific reimbursement for this line of $90.91 is multiplied by 200% for a MAR of $181.82.
- Procedure code 96375, February 27, 2016, has status indicator S, denoting significant OPPS procedures paid separately by APC, not subject to reduction. This is classified under APC 5692, which, per OPPS Addendum A, has a payment rate of $42.31, multiplied by 60% for an unadjusted labor-related amount of $25.39, which is multiplied by the facility's annual wage index of 0.9731 for an adjusted labor amount of $24.71. The non-labor related portion is 40% of the APC rate, or $16.92. The sum of the labor and non-labor portions is $41.63. The cost of these services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific reimbursement for this line of $41.63 is multiplied by 200% for a MAR of $83.26.
- Procedure code L1830, February 28, 2016, has status indicator A, denoting services paid using a fee schedule or payment system other than OPPS. If Medicare pays using other systems, Rule §134.403(h) requires the services be paid under the division guideline appropriate to those items on the date provided. Durable medical equipment, prosthetics, orthotics and supplies are paid using DWC's Professional Guideline, Rule §134.203(d)(1). The Medicare DMEPOS Fee Schedule rate for this code is $77.98. 125% of this amount is $97.48. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of $50.00. The lesser amount is $50.00.
- Procedure code 97001, February 28, 2016, has status indicator A, denoting services paid using a fee schedule or payment system other than OPPS. If Medicare pays using other systems, Rule §134.403(h) requires the services be paid under the division guideline appropriate to those items on the date provided. Professional services are paid using the DWC Professional Medical Fee Guideline, Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, the first unit of the procedure with the highest practice expense is paid in full. Payment for the practice expense of each subsequent unit is reduced by 50%. This procedure has the highest practice expense for this date. The Medicare rate for this code for 2016 is $72.81. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the Division conversion factor of 56.82 yields a MAR of $115.48. However, as stated above, the provider failed to bill the requisite severity modifier(s) on the accompanying functional G-codes required per Medicare payment policies. Thus, additional reimbursement cannot be recommended.
- Procedure code 97116, February 28, 2016, has status indicator A, denoting services paid using a fee schedule or payment system other than OPPS. If Medicare pays using other systems, Rule §134.403(h) requires the services be paid under the division guideline appropriate to those items on the date provided. Professional services are paid using the DWC Professional Medical Fee Guideline, Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, the first unit of the procedure with the highest practice expense is paid in full. Payment for the practice expense of each subsequent unit is reduced by 50%. This procedure does not have the highest practice expense for this date. The reduced rate for this code for 2016 is $21.05. This amount divided by the Medicare conversion factor of 35.8279 and multiplied by the Division conversion factor of 56.82 yields a MAR of $33.39. However, as stated above, the provider failed to bill the requisite severity modifier(s) on the accompanying functional G-codes required per Medicare payment policies. Thus, additional reimbursement cannot be recommended.
- Procedure codes G8978, G8979, and G8980 February 28, 2016, have status indicator E, denoting excluded or non-covered codes. These three codes are required by Medicare for functional data reporting purposes only; they do not represent a payable service and are not assigned separate reimbursement.

- Procedure code J7060, J7120, J0690, J1170 and J3010, February 28, 2016, have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code 80053 and 81001, February 28, 2016, have status indicator Q4, denoting packaged laboratory services. Separate payment allowed at Clinical Laboratory Fee Schedule rates if the bill contains only status Q4 HCPCS codes listed in the CLFS; otherwise, payment for the packaged services is included in the reimbursement for the primary service(s).
- Procedure code 27664, February 28, 2016, has status indicator T, denoting significant procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This procedure is paid at 100%. This is assigned APC 5122. Per OPPS Addendum A, the payment rate is $2,395.59, multiplied by 60% for an unadjusted labor-related amount of $1,437.35, which is multiplied by the facility's annual wage index of 0.9731 for an adjusted labor amount of $1,398.69. The non-labor related portion is 40% of the APC rate, or $958.24. The sum of the labor and non-labor portions is $2,356.93. The cost of these services does not exceed the annual fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific reimbursement for this line of $2,356.93 is multiplied by 200% for a MAR of $4,713.86.

5. The total allowable reimbursement for the disputed services is $5,985.34. The amount previously paid by the insurance carrier is $4,388.17. The requestor is seeking additional reimbursement of $1,392.14. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,392.14.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,392.14, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	March 24, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.